

GEORGIA STATE BOARD OF WORKERS' COMPENSATION**MOTION / OBJECTION TO MOTION**☐ Motion☐ Objection to Motion☐ Objection to WC-25☐ Objection to Rehab

When you receive this completed form, you may file a response with the Board within fifteen (15) days of the date of the certificate of service (O.C.G.A. § 9-11-6 (e)) All responses must be filed on Form WC-102D.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury		Address		
E-mail Address			City	State	Zip Code
EMPLOYER	Name		INSURER / SELF-INSURER	Name	
Address			CLAIMS OFFICE	Name	
City			Address		
State			City	State	Zip Code
Zip Code			City		
Employer E-mail			Claims E-mail		
ATTORNEY FOR EMPLOYEE / CLAIMANT	Name		ATTORNEY FOR EMPLOYER / INSURER	Name	
Address			Address		
City			City		
State			State		
Zip Code			Zip Code		
GA Bar Number			GA Bar Number		
Attorney E-mail			Attorney E-mail		

B. ACTION REQUESTED

<input type="checkbox"/> 1. This MOTION is being requested by	<input type="checkbox"/> Employee	<input type="checkbox"/> Employer/Insurer	<input type="checkbox"/> Other Party
The purpose of this motion is to request:			
(Arguments and documentation in support of this motion are attached.)			
<input type="checkbox"/> 2. This OBJECTION is being submitted by	<input type="checkbox"/> Employee	<input type="checkbox"/> Employer/Insurer	<input type="checkbox"/> Other Party
The purpose of this objection is to request:			
(Arguments and documentation in support of this objection are attached.)			

C. ENTRY OF APPEARANCE

<input type="checkbox"/> I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or Form WC 102B filed in compliance of Board Rule 102. (A fee contract or Form WC 102B has been filed previously or is attached).
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D. CERTIFICATE OF SERVICE

<input type="checkbox"/> I hereby certify that the parties have made a good faith effort to reach agreement on this issue, but have failed to do so to date. I further certify that I have this day sent a copy of this form with supporting documentation to the State Board of Workers' Compensation and to all parties and counsel in this claim.		
Print Name Here	Signature	Date
Phone Number	E-mail Address	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).